IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

November 3, 2010

Merinda Halladay, Administrator
Belmont Care Center
3625 Vaughn Street
Pocatello, ID 83204

RE: Belmont Care Center, Provider #13G046

Dear Ms. Halladay:

This is to advise you of the findings of the Medicaid/Licensure survey of Belmont Care Center, which was conducted on October 21, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner**:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of

being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **November 15, 2010,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by November 15, 2010. If a request for informal dispute resolution is received after November 15, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

Trish O'Hara

TRISH O'HARA
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/srm
Enclosures

BELMONT
CARE CENTER

3625 Vaughn Avenue
Pocatello, Idaho 83204

November 12, 2010

Nicole Wisenor, Supervisor Non-Long Term Care
Facility Standards Division of Medicaid
3232 Elder Street
Boise, Idaho 83705-4711

Dear Ms. Wisenor:

Attached is the original copy of the CMS-2567 for Belmont and Crestview Surveys concluded on 10/21/10. Please call if you or your team has any questions or concerns. I would like to continue to express my gratitude for how professional and helpful your surveyors were during this survey. We appreciate the support from you and your team. Trish, Jim and Michael have our sincere respect and represented your office in an outstanding manner. Please extend our teams appreciation to them.

Sincerely,

M. Halladay

Merinda Halladay
Belmont Mgt. Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G046	A. BUILDING _____ B. WING _____	10/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT CARE CENTER	3625 VAUGHN STREET POCATELLO, ID 83204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Trish O'Hara, RN, Team Lead Michael Case, LSW, QMRP Common abbreviations/symbols used in this report are: AQMRP - Assistant Qualified Mental Retardation Professional HRC - Human Rights Committee IPP - Individual Program Plan NOS - Not Otherwise Specified RN - Registered Nurse	W 000	**Preparation and implementation of this plan of correction does not constitute admission or agreement by Belmont Management with the facts, findings, or other statements as alleged by the Bureau of Facility Standards dated October 21, 2010. Submission of this plan of correction is required by law and does not evidence the truth of some of the findings as stated by the survey agency. Belmont Management specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action.**	
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on review of investigations and staff interviews, it was determined the facility failed to ensure potential abuse was prevented while an investigation was in process for 1 of 1 individuals (Individual #8), who was the victim of assault. This resulted in the potential for further assaultive behavior to occur while the investigation was completed. The findings include: An Incident/Accident report, completed 7/31/10, stated Individual #2 assaulted Individual #8. Written statements were taken from attending staff members and an investigation was completed. The Incident/Accident report and the	W 155	**POC W155 483.420(d)(3)** **STAFF TREATMENT OF CLIENTS** Belmont will ensure that protective measures are immediately taken to ensure the safety of individuals while an investigation is being conducted. In addition, the protective measures will be addressed in the complete investigation. The Administrator or Administrative Designee will give the staff immediate measures to take upon the report from the staff. This will be implemented until further direction is given and permanent correction is in place. The measures will protect and prevent further potential abuse to individuals during the investigation process. The protective measures will also be addressed between shift changes with supervisors and sent out in memo form. This will ensure all staff receive the needed	~~12/4~~

RECEIVED
DEC - 7 2010
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
M. Hallaway	Administrator	12/3/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 155	Continued From page 1 investigation did not document that measures had been taken immediately after the assault and during the investigative process to ensure Individual #8's protection from further potential abuse. During an interview on 10/21/10 at 10:00 AM, the AQMRP stated no protective action had been implemented to ensure protection of Individual #8 during the course of the investigation. The facility failed to ensure immediate measures were taken to prevent further potential abuse of Individual #8 during the investigative process.	W 155	information. Person Responsible: Administrator, Administrative Designee, and Supervisors. Monitor: The Administrator or Administrative Designee will discuss with any supervisor the protective and preventative measures implemented. In addition, the Administrator or Administrative Designee will watch on the cameras and do random checks to ensure the staff are following the instructions for the protective action.	12/18/10
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 4 of 4 individuals, (Individuals #1 - #4), whose restrictive interventions were reviewed. This resulted in a lack of protection of individuals' rights through prior approvals of restrictive interventions. The findings include: 1. Individual #1's IPP, dated 8/31/10, documented a 21 year old male diagnosed with moderate mental retardation, impulse control disorder, NOS, sexual misconduct, and narcissistic	W 262	**POC W262 483.450(f)(3)(i) PROGRAM MONITORING & CHANGE** HRC approval will be updated for all restrictive medications and interventions that are not currently updated. The Behavior Specialist is working with members of HRC to ensure all plans and consents are current. Belmont will ensure that HRC approval is obtained and kept current for all restrictive medications and interventions. Nursing will ensure that prior to the implementation of a restrictive medication the Human Rights Committee has given approval. The Behavior Specialist will meet monthly with the Human Rights Committee to review any proposed implementation or changes to restrictive medications and interventions.	

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W 262	Continued From page 2 personality traits versus disorder with considerable sociopathy. Review of Individual #1's record showed 4 restrictive interventions. These included: - A behavioral program, titled Hurtful to Others Program, employing Mandt restraint techniques of body blocking, one person one arm standing restraint, one person two arm standing restraint, and two person one arm standing restraint. - Psychotropic medications Seroquel, Trileptal, and Luvox. The record did not document HRC approval for the restrictive interventions. In an interview on 10/21/10 between 9:45 - 11:00 AM, the Administrator stated HRC approval for the restrictive program and medications for Individual #1 had not been obtained. The facility failed to ensure HRC approval had been obtained prior to the implementation of Individual #1's restrictive interventions. 2. Individual #2's IPP, dated 6/15/10, documented a 27 year old male diagnosed with mild mental retardation, antisocial personality disorder, fetal alcohol syndrome, mild cerebral palsy, paraphilia, and oppositional defiant disorder. Review of Individual #2's record showed a psychotropic medication, Clonidine, used for impulse control. There was no current HRC approval for this restrictive in Individual #2's record.	W 262	Person Responsible: Behavior Specialist, LPN, RN, QMRP(s) and Administrator Monitor: The Behavior Specialist will maintain a list of restrictive medications and interventions with the expiration date. This list will be reviewed monthly on Behavior Meeting along with any consents that may expire. In addition, the Behavior Specialist will maintain a list of proposed restrictive medications and interventions to take to the Human Rights Committee. Once approval is given the Behavior Specialist will notify the QMRP and Nursing. A copy of the updated lists will then be given to the QMRP and Nursing staff.	12/18/10

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W 262	Continued From page 3 In an interview on 10/21/10 between 9:45 - 11:00 AM, the Administrator stated there was no current HRC approval for the restrictive in Individual #2's record. The facility failed to ensure HRC approval was current for Individual #2's restrictive intervention. 3. Individual #3's IPP, dated 6/12/10, documented a 33 year old male diagnosed with mild mental retardation,anxiety, major depressive disorder, and adjustment disorder. Review of Individual #3's record showed the following restrictive interventions: - A behavioral program titled Treatment Restrictions - Guardian. This behavioral program cited restrictions including the individual remaining in line of sight while in the facility, within arm's length and line of sight while in the community, and having five minute visual checks by staff when sleeping. Additionally, Individual #3 was not allowed to sit directly next to other individuals, was required to keep both hands at or above table level when dining, and was not allowed to use the restroom until it was checked by staff. - The psychotropic medication Geodon. There was no current HRC approval in the record for the restrictive program and medication. In an interview on 10/21/10 between 9:45 - 11:00 AM, the Administrator confirmed there was no current HRC approval in Individual #3's record for the restrictive program and medication.	W 262		

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W 262	Continued From page 4 The facility failed to ensure HRC approval was current for Individual #3's restrictive interventions. 4. Individual #4's IPP, dated 7/21/10, documented a 25 year old male diagnosed with schizoaffective disorder, post traumatic stress disorder, mild mental retardation, and schizotypical personality disorder. Review of Individual #4's record showed the psychotropic medications Imipramine,Wellbutrin, Abilify, Eskalith, and Zoloft. There was no current HRC approval in the record for the restrictive medications. In an interview on 10/21/10 between 9:45 - 11:00 AM, the Administrator stated there was no current HRC approval for the restrictive medications in Individual #4's record. The facility failed to ensure HRC approval was current for Individual #4's restrictive interventions.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure restrictive interventions were implemented only with the written informed consent of the parent/guardian for 3 of 4 individuals (Individuals #2 - #4), whose restrictive interventions were reviewed. This resulted in a lack of protection of	W 263	**POC W263 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE** Client/guardian approval will be updated for all restrictive medications and interventions that are not currently updated. The Behavior Specialist is working with clients/guardians to ensure all plans and consents are current. Belmont will ensure written informed consent from the client/guardian is obtained and kept current for all restrictive medications and interventions. Nursing will ensure that prior to the implementation of a restrictive medication the client/guardian has given approval.	

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W 263	Continued From page 5 individuals' rights through prior consent for restrictive interventions. The findings include: 1. Individual #3's IPP, dated 6/12/10, documented a 33 year old male diagnosed with mild mental retardation,anxiety, major depressive disorder, and adjustment disorder. Review of Individual #3's record documented the following two restrictive interventions: - The psychotropic medication Geodon. - A behavioral program titled Treatment Restrictions - Guardian. This behavioral program cited restrictions including the individual remaining in line of sight in the facility, within arm's length and line of sight while in the community, and having five minute visual checks by staff when sleeping. Additionally, Individual #3 was not allowed to sit directly next to other individuals, was required to keep both hands at or above table level when dining, and was not allowed to use the restroom until it was checked by staff. There was no written consent present in the record. In an interview on 10/21/10 between 9:45 - 11:00 AM, the Administrator stated guardian consents for the restrictive program and medication for Individual #3 had not been obtained. The facility failed to ensure guardian consents were obtained for the restrictive program and medication for Individual #3. 2. Individual #2's IPP, dated 6/15/10, documented	W 263	The Behavior Specialist will contact the individual/guardian to review any proposed implementation or changes to restrictive medications and interventions. The Behavior Specialist will ensure the individual/guardian is given written informed information to make their decision. Person Responsible: Behavior Specialist, LPN, RN, QMRP(s) and Administrator Monitor: The Behavior Specialist will maintain a list of restrictive medications and interventions with the expiration date. This list will be reviewed monthly in Behavior Meeting along with any consents that may expire. In addition, the Behavior Specialist will maintain a list of proposed restrictive medications and interventions in order to contact the individual/guardian and obtain approval prior to the implementation of the restrictive medication or intervention. Once approval is given the Behavior Specialist will notify the QMRP and Nursing. A copy of the updated lists will then be given to the QMRP and Nursing staff.	12/18/10

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W 263	Continued From page 6 a 27 year old male diagnosed with mild mental retardation, antisocial personality, fetal alcohol syndrome, mild cerebral palsy, paraphilia, and oppositional defiant disorder. Review of Individual #2's record documented a restrictive psychotropic medication, Clonidine, used for impulse control. There was no current guardian consent for this restrictive medication in Individual #2's record. In an interview on 10/21/10 between 9:45 - 11:00 AM, the Administrator stated there was no current consent from the guardian for the restrictive medication in Individual #2's record. The facility failed to ensure guardian consent was current for restrictive medication for Individual #2. 3. Individual #4's IPP, dated 7/21/10, documented a 25 year old male diagnosed with schizoaffective disorder, Post Traumatic Stress Disorder, mild mental retardation, and schizotypical personality. Review of Individual #4's record showed the psychotropic medications Imipramine, Wellbutrin, Abilify, Zoloft, and Eskalith. There was no current guardian consent for these restrictive medications in Individual #4's record. In an interview on 10/21/10 between 9:45 - 11:00 AM, the Administrator confirmed there was no current consent from the guardian for the restrictives in Individual #4's record. The facility failed to ensure guardian consent was current for restrictive medications for Individual #4.	W 263		

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W 324	483.460(a)(3)(ii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure immunizations as recommended by the Public Health Service Advisory Committee were provided for 1 of 4 individuals (Individual #1) whose records were reviewed. This resulted in the potential for preventable illness to occur. Findings include: Individual #1's IPP, dated 8/31/10, documented a 21 year old male diagnosed with moderate mental retardation. His admission date to the facility was 8/10/10. Individual #1's medical record was reviewed. An Immunization and Inoculation form documented Tuberculosis testing done on 8/10/10. The remainder of the form, indicating the administration of other immunizations, was blank. In an interview on 10/21/10 between 9:45 - 11:00 AM, the facility nurse stated immunizations records were not present for Individual #1 for Diptheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella, Chickenpox, and Hepatitis B and no immunizations had been administered to Individual #1 since his admission on 8/10/10. She further stated antibody titers had not been	W 324	**POC W324 483.460(a)(3)(ii) PHYSICIAN SERVICES** All individual records were reviewed to ensure all immunizations have been completed. Records and documentation is in their nursing records. Upon admission, Belmont will work to obtain immunization records from individual's prior placement. When this is not available, written documentation by a Qualified Medical Professional will be utilized if the documentation includes the year of the vaccination. If the documentation is of a titer being drawn for the immunization, the accepting physician will determine, based on the date of the titer, health status of the individual and risk factors if and when either a new titer should be drawn or a booster series will be performed to ensure adequate disease immunity. If there is no documentation regarding immunizations, a titer will be drawn to determine the levels of immunization. The levels will be reviewed by the accepting physician to determine the steps necessary to ensure immunizations are current. Person Responsible: LPN, RN and Administrator Monitor: Upon admission the LPN will review all medical information to determine the route necessary to ensure immunizations have occurred and are current. If documentation was not submitted by the prior placement, the LPN will contact them to attempt to obtain documentation. If there	

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W 324	Continued From page 8 obtained to verify Individual #1's immunity to these diseases. The facility failed to ensure Individual #1 obtained/maintained immunity to communicable diseases as recommended by the Public Health Service Advisory Committee.	W 324	is no documentation regarding immunizations, the LPN will work with the Doctor to have a titer drawn. Once the results of the titer are obtained, the LPN will work with the physician to determine the needed immunizations.	
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.	W 436	Individual records will be reviewed quarterly to ensure the necessary immunization records are in the individuals nursing record.	12/18/10
	This STANDARD is not met as evidenced by: Based on record review, staff interview and observation, it was determined the facility failed to ensure individuals were provided with eyeglasses for 1 of 1 individuals (Individual #1) who required eyeglasses. This resulted in an individual having potentially decreased functioning due to poor visual acuity. The findings include: 1. Individual #1's IPP, dated 8/31/10, documented a 21 year old male diagnosed with moderate mental retardation. His medical record included documentation of an eye exam, dated 9/3/10. The exam recommended prescription eyeglasses. His IPP, dated 8/31/10, stated he was to wear his glasses during all waking hours due to visual impairment. During observations conducted at the facility on 10/18/10 from 4:35 - 6:00 PM and 10/19/10 from		**POC W436 483.460(g)(2) SPACE AND EQUIPMENT** Belmont will furnish and maintain in good repair adaptive equipment related to dentures, eyeglasses, hearing and other communications aids, braces, and other devices needed by the individual. Belmont will ensure upon the recommendation of the adaptive need, ordering and follow up is completed. A review of all individuals' adaptive equipment was completed. Any adaptive equipment that was needed or in need of repairs was ordered or fixed. Person Responsible: LPN, RN, QMRP and Administrator Monitor: Once a need for replacement, repair, or initial ordering of adaptive	

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W 436	Continued From page 9 10:00 - 10:45 AM and 10/19/10 from 11:10 AM - 12:15 PM, Individual #1 was not observed wearing glasses. Individual #1's annual nursing summary, dated 8/31/10, stated the optical company was unable to verify payment eligibility for Individual #1 at the time of the eye exam but would contact the facility when verification was complete. During an interview on 10/21/10 at 10:00 AM, the facility nurse stated Individual #1 did not have his eyeglasses. She said she had not followed up with the optical company to ensure glasses were obtained for Individual #1. The facility failed to provide prescription eyeglasses for Individual #1.	W 436	equipment is identified, the CNA or LPN will fill out an Adaptive Equipment Checklist. The checklist will be placed in the front of the file and will denote what equipment is an issue, when and by whom the need was identified, if and when an appointment must be made, the order date or the date the equipment was sent out of the facility for repair and the date that the equipment was returned to the client. The individuals Primary LPN will review the forms weekly and note any follow up.	12/18/10
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases. This failure directly impacted 5 of 5 individuals, (Individuals #2, #3, #5, #6, and #7), observed during medication administration, and had the potential to impact all individuals (Individuals #1 - #9) residing in the facility. This had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include:	W 455	**POC W455 483.470(l)(1) INFECTION CONTROL** Belmont will ensure the prevention and control the infection of communicable diseases during medication passes by posting the proper infection control procedures in the medication room. The proper and trained procedure for medication passes will be conducted prior to each individual taking their medications. Person Responsible: LPN, RN, Home Supervisor and Administrator Monitor: The procedures for appropriate infection control while passing medications will be posted in the medication room. Annually all staff will be required to re-take	

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	13G046	A. BUILDING _____ B. WING _____	10/21/2010

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W 455	Continued From page 10 An observation was conducted at the facility on 10/19/10 between 6:30 - 8:00 AM. During that time the following was observed: - At 6:55 AM staff disinfected the medication room counters and sink, washed his hands, and put on disposable gloves. - At 7:00 AM Individual #6 entered the medication room. He did not wash his hands before placing medication directly in his hand. - At 7:05 AM Individual #7 entered the medication room. He did not wash his hands before placing medication directly in his hand. Staff did not change gloves and did not wash his hands between medication administration for Individual #6 and Individual #7. - At 7:20 AM Individual #2 entered the medication room and self initiated hand washing. Staff did not wash his hands and did not change gloves between medication administration for Individual #7 and Individual #2. He had used his gloved hands to reach in his pockets as well as handle the medication book and medication baskets. - At 7:25 AM staff removed his gloves, locked the cabinets and left the medication room. - At 7:35 AM staff and Individual #3 entered the medication room. Individual #3 did not wash his hands before taking his medication. Staff put on clean gloves but did not wash his hands before gloving between Individual #7's and Individual #3's medication administration. - At 7:40 AM staff removed his gloves and left the medication room.	W 455	the Medication passing procedures and infection control when passing medications with Nursing staff. In addition, there will be monthly spot checks done by the home supervisors and nursing staff to ensure the appropriate infection control is occurring during medication passes.	12/18/10

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W 455	Continued From page 11 - At 7:55 AM staff and Individual #5 entered the medication room. Individual #5 did not wash his hands before placing medication directly in his hand. Staff put on clean gloves but did not wash his hands before gloving between Individual #3's and Individual #5's medication administration. In an interview on 10/21/10 between 9:45 - 11:00 AM, the facility RN stated infection control procedures included staff changing gloves and washing their hands between each individual's medication administration routine. Additionally, she said staff should prompt individuals to wash their hands before taking medications. The facility failed to ensure infection control procedures were followed during medication administration.	W 455		

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensure survey. The survey was conducted by: Trish O'Hara, RN, Team Lead Michael Case, LSW, QMRP	M 000	RECEIVED DEC - 7 2010 FACILITY STANDARDS	
MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W155.	MM177	**POC MM177 16.03.11.075.09** **Protection from Abuse and Restraint** Refer to W155	12/18/10
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	**POC MM194 16.03.11.075.10(a)** **Approval of Human Rights Committee** Refer to W262	12/18/10
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by:	MM196	**POC MM196 16.03.11.075.10(c)** **Consent of Parent or Guardian** Refer to 263	12/18/10

Bureau of Facility Standards

M. Hallady — TITLE Administrator — (X6) DATE 12/3/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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MM196	Continued From page 1 Refer to W263.	MM196		
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept in good repair for 9 of 9 individuals (Individuals #1 - #9) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: An environmental review was conducted on 10/20/10 from 11:55 AM - 1:15 PM. During that time the following was noted: - Individual #6's dresser was missing the bottom drawer. - Individual #9's closet had broken doors and was missing a door. His dresser was missing a back leg. - Individual #8's room had a closet with a twelve inch by three inch section that was broken and a four inch hole in the side. - Individual #4's closet had two broken doors. The drape rod in this room was pulled from the brackets.	MM380	**POC MM380 16.03.11.120.03(a) Building and Equipment** 1. Individual #6's drawer will be repaired and reunited with the dresser. 2. Individual #9's closet will be replaced. 3. Individual #8's closet will be replaced. 4. Individual #4's closet will be replaced. The drape rod will be repaired. 5. Individual #7's bed will be repaired so the mattress is not able to fall through. A wall plate will place on the outlet. The baseboard heater will be fixed. 6. Individual #3's dresser was moved away from the window. 7. Individual #2's closet will be replaced. 8. The missing handle on the refrigerator in the dinning room will be replaced. 9. The drawer in the medication room will be repaired. 10. The missing drawer and rail in the refrigerator in the kitchen will be replaced. 11. The drawers in the kitchen to the left of the dishwasher will be repaired.	

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MM380	Continued From page 2 - Individual #7's bed frame was broken on the top right side, causing the mattress to fall through. The wall plate on the outlet between the beds in this room was missing a cover plate. The baseboard heater in this room was broken on the end, exposing sharp metal edges. - Individual #3's closet was in front of the window, preventing egress. - Individual #2's closet had a door that was broken off. - The refrigerator in the dining room was missing a door handle. - The medication room had a drawer to the left of the sink that was broken from the rails. - The refrigerator in the kitchen was missing a drawer and a door rail. - Two drawers in the kitchen, to the left of the dishwasher, were broken from the rails. The facility failed to ensure environmental repairs were maintained.	MM380	Person Responsible: Maintenance, Housekeeping, Residential Home Supervisor, and Administrator Monitor: Monthly facility inspections be completed by the Home Supervisor and Housekeeping. Quarterly the Administrator will complete facility inspections.	12/18/10
MM426	16.03.11.120.10(a) Plumbing Fixtures All plumbing fixtures must be clean and in good repair. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure all plumbing fixtures were kept in good repair for 9 of 9 individuals (Individuals #1- #9) residing in the facility. The findings include:	MM426	**POC MM426 16.03.11.120.10(a) Plumbing Fixtures** The traps on the three sinks have been cleaned out. A plumber will be contacted to look at flow issues and solutions for repair. Repairs will then be made. Person Responsible: Housekeeping, Residential Home Supervisor, and	

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MM426	Continued From page 3 An environmental assessment was conducted on 10/20/10 from 11:55 AM - 1:15 PM. During that time the following was noted: a. The sink drain in bathroom #1 drained at an excessively slow rate. With the water running, the sink would fill and reach the overflow drain in less than 60 seconds. b. The sink drain in bathroom #2 drained at an excessively slow rate. With the water running, the sink would fill and reach the overflow drain in less than 60 seconds. c. The sink drain in the medication room drained at an excessively slow rate. With the water running, the sink would fill and reach the overflow drain in less than 60 seconds. The Administrator was present during the environmental assessment and stated the drain had always been slow. The facility failed to ensure all sinks drained properly.	MM426	Administrator Monitor: Monthly facility inspections are completed by the Home Supervisor and Housekeeping. Quarterly the Administrator will complete facility inspections.	12/18/10
MM429	16.03.11.120.11 Equipment and Supplies for Resident Care Equipment and Supplies for Resident Care. Adequate and satisfactory equipment and supplies must be provided to enable the staff to satisfactorily serve the residents. This Rule is not met as evidenced by: Refer to W436.	MM429	**POC MM429 16.03.11.120.11 Equipment and Supplies for Resident Care** Refer to W436	12/18/10
MM548	16.03.11.210.02(g) Immunization Record of immunizations; and	MM548	**POC MM548 16.03.11.120.02(g)**	

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MM548	Continued From page 4 This Rule is not met as evidenced by: Refer to W324.	MM548	**Immunization** **Refer to W324**	12/18/10
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769	**POC MM769 16.03.11.270.03(c)(vi) Immunization** **Refer to W455**	12/18/10